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FILE COPY

Cheryl Baker, Administrator
606 Mason Rd
Caldwell, ID 83605

Dear Ms. Baker:

On December 12, 2006, a complaint investigation survey was conducted at Cheryl's Country Place. The survey was conducted by Rebecca Winter, RN and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00002344

Allegation #1: Residents are left in wet attends.

Findings: Based on interview and record review it was determined a resident was left in wet attends.

Review of the identified resident's care plan revealed the resident's attend was to be changed every two hours.

On December 12, 2006 at 11:15 a.m., 2 caregivers stated there were several incidents in which they found the identified resident in wet attends when they came on shift in the morning. Additionally, the caregiver who worked the evening shift stated she would date and initial the resident's attend when she changed her. Further the caregiver who worked the morning shift stated she was aware the evening caregiver dated and initialed the resident's attends and when she provided care for the identified resident on the morning shift the evening caregiver's initials were still on the wet attends.

Conclusion: Substantiated. However, the facility was not cited as they had given notice of discharge to their residents, and the facility license would be voluntarily surrendered.

Allegation #2: There is not enough food to eat.

Findings: Based on observation it was determined there was sufficient food in the facility to meet the needs of the residents.

On December 12, 2006 at 2:30 p.m. the refrigerators and cupboards were observed to contain sufficient quantities of food to meet the needs of the residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on December 12, 2006.

Allegation #3: There is no call system.

Findings: Based on observation and interview it was determined there was a call system, however the staff had not been trained in its use.

On December 12, 2006 at 10:30 a.m. the administrator's son stated the call system was in working order.

On December 12, 2006 at 10:35 a.m. the administrator's husband stated the call system was in working order.

On December 12, 2006 at 10:40 a.m. the call system was observed to consist of a two-way voice monitoring system with the speaker board with switches for each room on the wall in the dining room area. Each room has a speaker also. The owner's son went into one of the rooms and his voice could be heard very audibly over the speaker in the dining room.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on December 12, 2006.

Allegation #4: There are two residents that require two person assistance. However, there was only one caregiver on duty during the night shift.

Findings: Based on observation, interview and record review it could not be determined there were two residents that required two person assistance.

Review of all resident care plans revealed no documented evidence that any of the 4 current residents required two person assistance.

On December 12, 2006 at 11:15 p.m., a caregiver stated all except for one of the current residents were either independent or required minimal assistance with activities of daily living. Additionally, the caregiver stated the one resident who required total assistance could be managed by one person unless the resident had a fall and was on the floor.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on December 12, 2006.

Allegation #5: The facility may be operating without a licensed administrator.

Findings: Based on interview and record review it was determined the administrator of record did have a valid license, therefore the facility was not operating without a licensed administrator.

Review of the internet based listing of licenses on December 14, 2006 revealed the administrator of record held a Residential Care Facility Administrator's license that would expire on December 11, 2007.

On December 12, 2006 at 10:30 a.m. the administrator's husband stated he had mailed the renewal form for his wife's Residential Care Facility Administrator's license.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on December 12, 2006.

Allegation #6: There have been no nursing assessments since March, 2006.

Findings: Based on interview and record review it was determined the 90-day nursing assessments were completed.

Review of four random resident records on December 12, 2006 revealed documented evidence nursing assesments were conducted on December 1, 2006.

On December 12, 2006 at 3 p.m. the administrator's husband stated the RN did conduct nursing assessments on the residents on December 1, 2006.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on December 12, 2006.

Allegation #7: The facility does not have a nurse.

Findings: Based on interview and record review it was determined the facility did not have a licensed professional nurse, as the facility nurse had resigned effective December 1, 2006.

Review of a letter received by the survey and licensing agency on 12/3/06 revealed the licensed professional nurse had given the facility notice of her resignation to be effective on December 1, 2006.

On December 12, 2006 at 3:00 p.m. the administrator's husband confirmed the facility nurse had resigned and they had not found a new nurse to replace her.

Conclusion: Substantiated. However, the facility was not cited as they had given notice of discharge to their residents, and the facility license would be voluntarily surrendered.

Allegation #8: A resident fell out of her chair and sustained a scrape on the right side of her forehead. The facility only provided the resident with first aid treatment.

Findings: Based on interview and record review it was determined a resident fell out of her wheelchair, sustained a scrape on the right side of her forehead, and received only first aid treatment.

On December 12, 2006 at 11:00 a.m., the caregiver on duty during the time of the incident confirmed that on December 6, 2006 at 4:30 p.m., the identified resident fell out of her wheelchair and sustained a scrape on the right side of her forehead. Additionally, the caregiver confirmed the facility provided the resident with only first aid treatment.

Review of facility notes dated December 6, 2006 documented that the caregiver who found the resident on the floor called the administrator's son and the resident's hospice nurse to inform them of the fall. It was further documented the hospice nurse instructed the caregiver to clean the scrape, apply antibiotic cream and cover it with a bandage.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by providing the resident with first aid treatment. The facility was not cited as they had given notice of discharge to their residents, and the facility license would be voluntarily surrendered.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Debbie Sholley, LSW

DEBBIE SHOLLEY, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DS/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program